GUARDIAN PEDIATRICS

OVER 18 HIPAA RELEASE AND CONSENT FORM

I understand and acknowledge that as my 18th birthday, my parents and/or guardians will no longer be permitted access to any of my medical records (health and /or mental), without my written consent. Guardian Pediatrics will not speak with my parents/and or guardians, permit my parents/and or guardians to schedule appointments, or release medical information of any kind without my written consent in accordance with this document.

1. I ______________________________ hereby authorize Drs. Somes, McCollum, McKeever, Schulte and members of their staff to use and/or disclose my protected health information to the following:

   ______________________________ ______________________________

   ______________________________ ______________________________

2. Authorization for Release of Information.
   a. ____I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse).

   OR

   b. ____I hereby **authorize the release of my complete health record with the exception of the following information:**
      ____ Mental health records
      ____ Communicable disease (including HIV and AIDS)
      ____ Alcohol/drug abuse treatment
      ____ Other (please specify): ______________________________

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
4. This authorization shall be in force and effective as long as I remain a patient in this practice.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

ACKNOWLEDGEMENT OF RECEIPT OF GUARDIAN PEDIATRICS NOTICE OF PRIVACY PRACTICES:
By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

______________________________ ____________________
PATIENT PRINTED NAME DATE

______________________________ ____________________
PATIENT SIGNATURE PATIENT PHONE #